U.S. Army Medical Command (MEDCOM)

Educational and Developmental Intervention Services (EDIS)

School Year 2007/2008
Annual Report of Compliance

Submitted to
Office of the Secretary Of Defense
September 2008

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Executive Summary

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Background: Pursuant to the Individuals with Disabilities Education Act (IDEA), the Educational and Developmental Intervention Services (EDIS) provides educationally related allied health services (RS) to students receiving special education in DoD Dependents Schools (DoDDS) overseas, and provides early intervention services (EIS) to infants/toddlers (birth – 36 months) and their Families in communities supported by DoD schools in both domestic and overseas locations.

Guidance for implementation of the Individuals with Disabilities Education Act (IDEA) is contained in DoD Instruction 1342.12, "Provision of Early Intervention and Special Education Services to Eligible DoD Dependents." The Instruction requires an annual report on the status of compliance with IDEA. The reporting period for the annual report is 1 July through 30 June, with a census date of 31 March. This document meets the reporting requirement.

Program Description: The Army Medical Department is responsible for EDIS programs at 21 program sites across Europe, Asia and the United States. EDIS provides services in the child's natural environment or least restrictive setting and based on written service plans. The EDIS staff includes early childhood special educators and allied health providers, e.g., speech language pathologists, occupational therapists, physical therapists, nurses, social workers, and psychologists.

Status of Compliance: Headquarters, U.S. Army Medical Command (MEDCOM) and the Army Regional Medical Commands (RMCs) provide effective oversight, monitoring, and staff training to maintain program compliance. As of 30 June 2008, 18 of 22 Army EDIS programs fully met all applicable Department of Defense (DoD) compliance standards. Army EDIS programs provide quality services and employ best practices in the field of early childhood intervention. Based on reports submitted by the field, the EDIS programs that were not in full compliance at the end of the reporting period had partial deficiencies in a single standard each. A continuing staff vacancy at two locations resulted in un-served or under-served children. At the end of this reporting period, vacancies had not been filled, but actions had been taken to recruit personnel and services will be in place by the beginning of the school year. Qualified providers who are willing to relocate to overseas are difficult to find. Headquarters MEDCOM has administratively fenced the funds for EDIS to ensure continued compliance with DoD standards and Public Law. Funding has been programmed to support an increase in staff to correct any deficiencies and to meet the identified needs in EDIS.

Program Operational Data: The Special Needs Management Information System (SNPMIS) provides data for meaningful process improvement activities and continuous compliance monitoring by higher headquarters. Section C of this report contains the operational data required for this report. In addition to the required data tables, the following pages provide a comprehensive summary analysis of Army EDIS operations over the past several years, with comparisons to National data used as benchmarks for success.

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Analysis of Army EDIS Operational Data

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Reporting Period: 1 July 2007 – 30 June 2008
Point in Time Census Data: 31 Mar 2008

Data Sources:
1) Special Needs Management Information System (SNPMIS), U.S. Army Medical Command roll-up reports (see data tables at Part C of this report).
2) U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs, *27th Annual (2005) Report to Congress on the Implementation of the Individuals with Disabilities Education Act,* vol. 1, Washington, D.C., 2007.

PROGRAM OVERVIEW

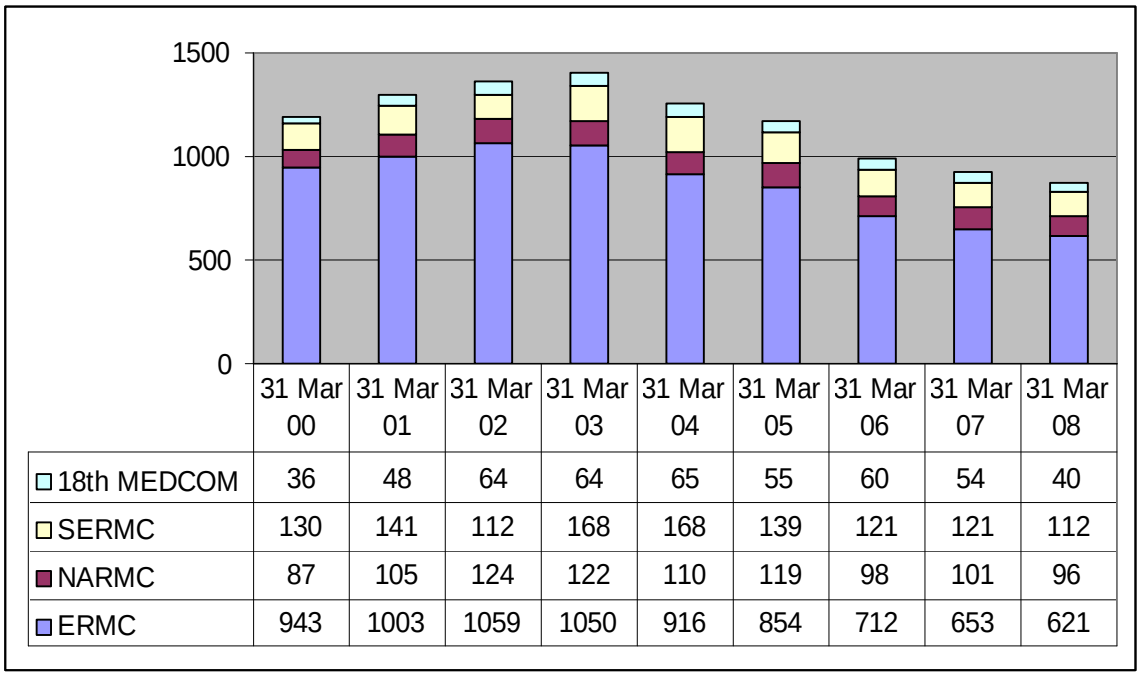
The Army operates EDIS programs at 9 domestic installations (includes Puerto Rico), 12 communities in Europe, and one in Korea. Our domestic programs provide only early intervention services (EIS) for infants and toddlers, while the overseas EDIS programs also provide related services (RS) to special education students in the DoD Dependents Schools. EIS are provided in accordance with a written Individualized Family Services Plans (IFSPs), and RS for school-aged children are documented on Individualized Educational Programs (IEPs).

POPULATION SERVED: On 31 Mar 2008, the 22 Army EDIS teams served 869 children on active service plans: 442 infants and toddlers (domestic and overseas) and 447 school-aged children (overseas only). This represents a decrease of 12.6 percent from last year, and a 36 percent decrease over the past 5 years.

Understanding the reasons for fluctuations in the number of service plans is important for projecting staffing and budgetary requirements for EDIS. Chart 1 shows the changes in total EDIS service plan count on 31 March of each year since we began aggregating this data. The total Army EDIS service plan count peaked on 31 Mar 03 and then steadily decreased, dropping by a total of 38 percent as of this current report. The effect of the Army drawdown in Europe has had the greatest impact on the decreased enrollment. The Army EDIS programs in Europe have experienced more than a 41 percent decrease in EDIS enrollment.

Although most of the decrease in active EDIS service plans occurred in Europe, which appears to be directly related to the Global War on Terror and the Army Transformation, there have also been significant decreases in service plans at many of the domestic EDIS sites. The decrease in enrollments in the Army's domestic programs might be attributable to the overall Army restructuring, since this phenomenon began a couple of years later than in Europe. This trend in declining caseloads is true for all EDIS programs except for EIS in Korea, which increased by 18 percent due to the recent restructuring of the forces in Korea and the increase in command sponsored Families.

Chart 1
Total EDIS Service Plan Count by Region
31 Mar 00 – 31 Mar 08



	31 Mar 00	31 Mar 01	31 Mar 02	31 Mar 03	31 Mar 04	31 Mar 05	31 Mar 06	31 Mar 07	31 Mar 08
18th MEDCOM	36	48	64	64	65	55	60	54	40
SERMC	130	141	112	168	168	139	121	121	112
NARMC	87	105	124	122	110	119	98	101	96
ERMC	943	1003	1059	1050	916	854	712	653	621

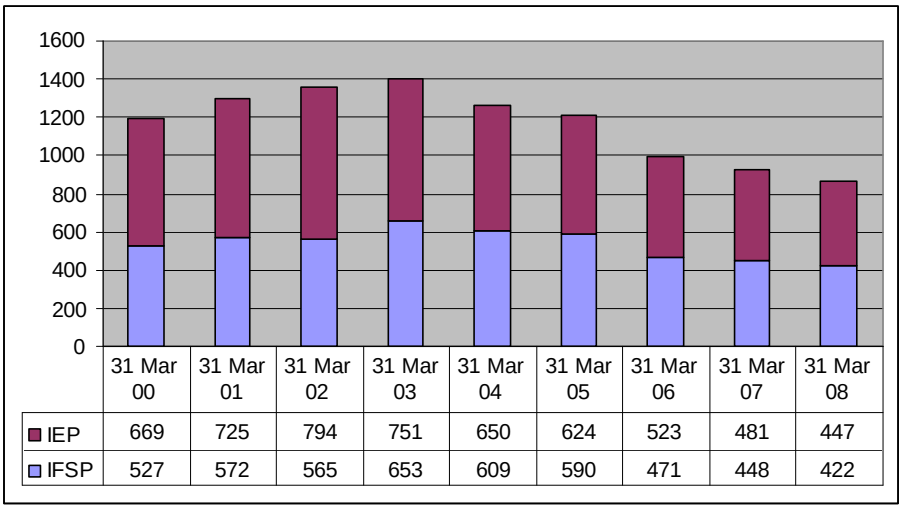
The decrease in EDIS enrollment has raised serious management concerns. With three of the 22 EDIS sites having 10 or fewer active service plans, a decrease of two or three service plans may have a significant impact on the ability to run a cost efficient program. Even with a handful of children, we must maintain access to services for eligible Families, and continue program oversight activities. Therefore, the reduction in EDIS providers has not kept pace with the decrease in service plans (see next section titled STAFFING).

A significant decrease in enrollment also has potential program compliance implications. It may indicate a failure in to conduct effective public awareness and child-find activities to locate and evaluate infants and toddlers who may have a disability or developmental delay. However, when we examine the number of children enrolled in the DoD schools in these communities, we find that the enrollment is declining proportionately, resulting in a decrease in EDIS services requested by the DoD schools. This confirms that there are fewer Families with children in the EDIS service areas. Chart 2 shows a greater decrease in IEP services (to school-age children) than to IFSPs (infants/toddlers), confirming that EIS conducts effective child-find activities.

At domestic locations, there is a unique limitation related to program eligibility. With the exception of Puerto Rico, Families must reside on the installation to be eligible for EIS from EDIS. Even if there is an increase or decrease in the total numbers of Soldiers assigned to a post, the potential population for EIS is limited by the number of available housing units on the installation.

A large number of housing units have been unoccupied and scheduled for replacement over the past 2-3 years as the Army upgrades installation infrastructures to support the restructuring. The emphasis on quality of life for Families has resulted in larger, but fewer, replacement units. Some locations reported that the low cost of quality housing in the local communities and the lower mortgage interest rates encouraged soldiers to purchase homes off post.

Chart 2
Annual Changes in Service Plan Count by Type of Service Plan
IEP vs. IFSP



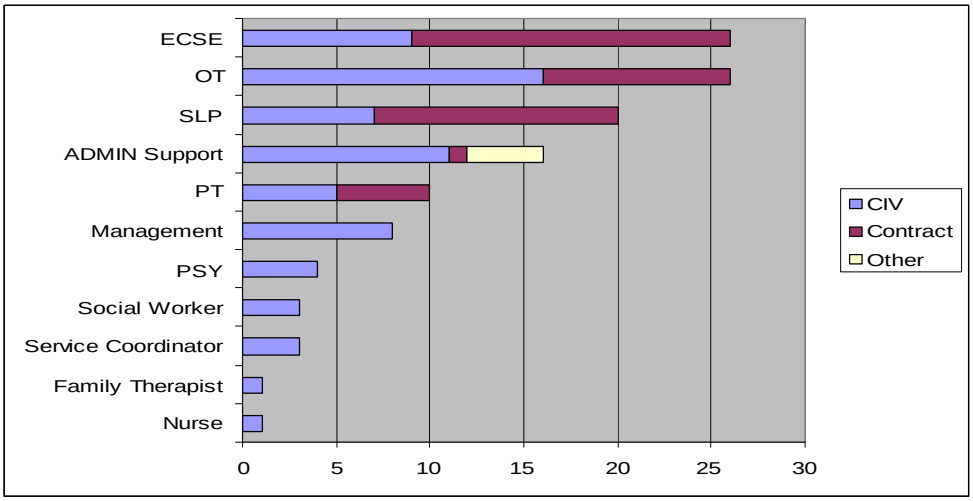
	31 Mar 00	31 Mar 01	31 Mar 02	31 Mar 03	31 Mar 04	31 Mar 05	31 Mar 06	31 Mar 07	31 Mar 08
IEP	669	725	794	751	650	624	523	481	447
IFSP	527	572	565	653	609	590	471	448	422

STAFFING: Unlike the Navy and Air Force, the Army does not utilize active duty personnel for delivery of services within EDIS. The Army EDIS staff consists of Civil Service employees and contractors. Lengthy vacancies in overseas areas during the SY 07/08 reporting period resulted in un-served or under-served children, primarily for OT services to special education programs in the DoD schools.

Multidisciplinary team in EDIS may vary in size and composition, depending on the anticipated enrollment and supporting resources available in the community. The core members of any EDIS team, CONUS and OCONUS are the Early Childhood Special Educator (ECSE), Speech Language Pathologist (SLP), and Occupational Therapist (OT). The ECSE and SLP are exclusively employed for EIS, and OT services are the most frequently requested service to school-aged children in overseas areas. Other provider disciplines may include Physical Therapists (PT), Family Counselors/Service Coordinators (FSC), Social Workers (SW), Nurses, and Psychologists (Psy).

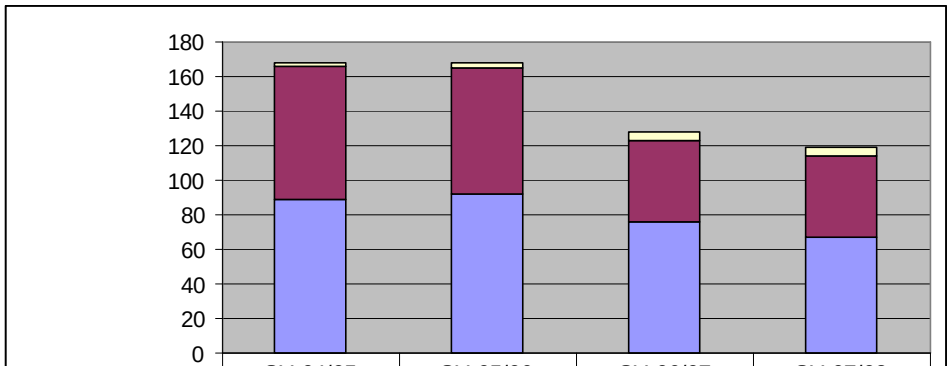
Out of a total EDIS personnel count of 118 on 31 Mar 08, 102 were direct service providers. Of the 102 providers, nearly half were contractors. Chart 3 shows the number of personnel in Army EDIS by discipline and type of employment. EDIS management personnel in small communities may serve dual roles as direct care providers and managers. These positions are counted under the provider's discipline.

Chart 3
Total Army EDIS staff by Discipline and Type of Employment -- 31 Mar 08



During the past four years, the Army has reduced the EDIS staffing by 29 percent. Chart 4 shows the change in staffing over the past 4 years as the enrollments in EDIS programs have declined. Although the staff was decreased by 8 percent from the last reporting period, the number of direct-care providers remained constant. As small military communities in Europe closed, and others drew down their population base, remaining smaller EDIS programs were combined into a single program serving a broader geographic area. This resulted in the reduction of management personnel. We do not expect a reduction in staff during this coming school year and will increase staff in Korea by three or four positions.

Chart 4
Changes in the Number of Army EDIS Providers Over 4 Years



	SY 04/05	SY 05/06	SY 06/07	SY 07/08
Other (LN & Mil)	2	3	5	5
Contractors	77	73	47	47
Civilians (GS)	89	92	76	67

Management of the personnel resources presents complex challenges in overseas areas. The Army restructuring in Europe resulted in the closure of several small Army communities. Some of the providers from the closed programs relocated to fill vacancies in other communities, or became excess providers. Excess EDIS providers also deliver a "value added" services through the primary care system.

Local and regional initiatives to reduce costs through resource sharing and changes in service delivery models have worked well, but are not always practicable. Because of distances involved, a core staff is required at each program location to ensure that EDIS provides appropriate services in a timely manner. Getting greater efficiencies is difficult when we must provide services in small dispersed communities throughout Europe, or on small installations in domestic areas. Several of the initiatives identified in Section B of this report lists initiatives EDIS has taken to maximize resources under these circumstances.

EDIS programs cannot reduce staff any further and still operate within DoD compliance standards. During the recent few years of military re-structuring, EDIS has been unable to approach any efficiency benchmarks. One measure is the ratio of EDIS providers to children enrolled in the program. On 31 Mar 07, we had an average ratio of 9 children per provider. This figure has dropped to 8.5 children per provider for this current reporting period. This figure is far from the commonly used ratio of 12:1 implemented by most state early intervention programs, and is a benchmark established in the MEDCOM policy for EIS. Until the Army stabilizes, this ratio will not improve.

SERVICE AFFILIATION OF ENROLLED FAMILIES: The DoD assigns responsibility for EDIS programs to the military medical departments by geographic area, regardless of the Service affiliation of the personnel stationed in the area. Army EDIS programs serve all DoD personnel within the geographic area of responsibility who meet the eligibility criteria for the DoD schools, including Active Duty military, DoD civilians, other Federal employees and certain contractors in overseas locations and Puerto Rico.

On 31 Mar 08, Army Families made up 90 percent of the total Army-wide enrollment for EIS (infants/toddlers), but less than 64 percent of the special education students receiving related services through EDIS. This is not surprising. The military medical departments provide related services to special education students only in overseas areas, and are more likely to have responsibility for tri-service DoD communities, and to serve DoD civilians. Air Force Families were made up slightly less than 18 percent of the total Army EDIS enrollment and DoD civilians were just over 6 percent.

In domestic EDIS program, the EIS enrollment consisted of nearly 94 percent Army Families. In overseas areas, Army Families made up less than 75 percent of the EIS enrollment.

EARLY INTERVENTION SERVICES (0 – 3 year olds)

Number of Children Served in Early Intervention Services (EIS): Army EDIS received a total of 2,063 new referrals for EIS and discharged 592 children during the reporting period. Over 98% of the infants and toddlers referred for evaluations became eligible for services. A total of 1,694 infants and toddlers received services on Individualized Family Service Plans (IFSPs) at some time during the reporting period.

Since the total number of service plans is in constant flux, we use the 31 March of each year as the point in time at which we take a census count of the number of active IFSPs we should expect to have on any given day. On 31 March 2008, Army EDIS had 422 active IFSPs.

Analysis of EIS Compliance Data: This section presents management data used to measure compliance with specific requirements of IDEA legislation and DoD policy.

Early and Effective Identification of Infants and Toddlers:

The public law emphasizes early identification of infants and toddlers with special needs. The premise of early intervention is tied to the construct that the earlier the intervention, the better the outcome. For our metric, we compared Army EDIS data on early identification to data reported by the U.S. Department of Education in its 27th Annual Report to Congress. Army EDIS has consistently met or exceeded the measures of success for this compliance area.

The child's age at referral provides a good measure of the effectiveness of our EIS public awareness and child-find activities. Of all children who received EIS from Army EDIS programs during the reporting period, 28 percent entered services at less than 12 months of age. Half of those were less than 6 months of age. This shows improvement from last year when just under 25 percent of children entering the program were under 12 months of age.

Forty one percent (41%) of children referred for EIS during this reporting period were between 12 and 24 months of age, and 31 percent were between 24 and 36 months. These are outstanding results that demonstrate effective child find processes.

The active enrollment on 31 March 2008 (point in time census) represents approximately 2.7 percent of the estimated number of all infants and toddlers birth through age 2 in the service area. This figure is slightly down from the 2.9 percent served last year, but still compares favorably with National data of 2.2 percent. Medical literature reports that approximately 3% of all infants/toddlers require some sort of intervention to enhance development.

National data shows that States are only serving 1 percent of all children under the age of 12 months. Children under 12 months of age who received services from Army EDIS on 31 Mar 08 represented 2.0 percent of that age group in the

EDIS catchment areas. This further confirms the success of our public awareness and child find activities. Table 1 below shows the comparison of Army data and the figures reported by the U.S. Department of Education.

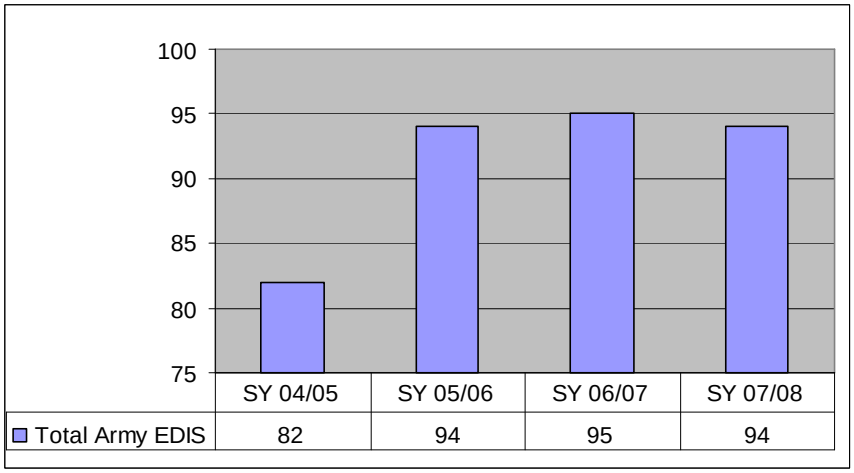
Table 1
Percentage of Population Served in Early Intervention

	U.S. Dept. of Education 27th Report to Congress	**Army EDIS SNPMIS Data SY 07/08**
Percentage of Total Population Served in Early Intervention, Birth to 12 months	.1%	2.0%
Percentage of Total Population Served in Early Intervention, Birth to 36 months	2.2%	2.7%

Timeliness of Services:

The DoD policy for EIS requires that EDIS complete all evaluations and develop a service plan for eligible infants and toddlers within 45 days from referral to EDIS. Four years ago, all Army EDIS programs implemented a process improvement initiative to improve compliance with this requirement. As illustrated in Chart 5, Army compliance has remained at 94 to 95 percent over the past 3 years. Compliance monitoring activities during the past year revealed that EDIS programs appropriately documented the reasons for the delays, and all were due to unavailability of the Families. Therefore, the adjusted compliance rate is 100 percent.

Chart 5
Percentage of Families who Received Service Plans
Within 45 days of Referral to EDIS



With the nature of the military life, these figures will remain the benchmark for compliance, providing the reasons for the missed timeline is documented and that reason is not within the control of EDIS.

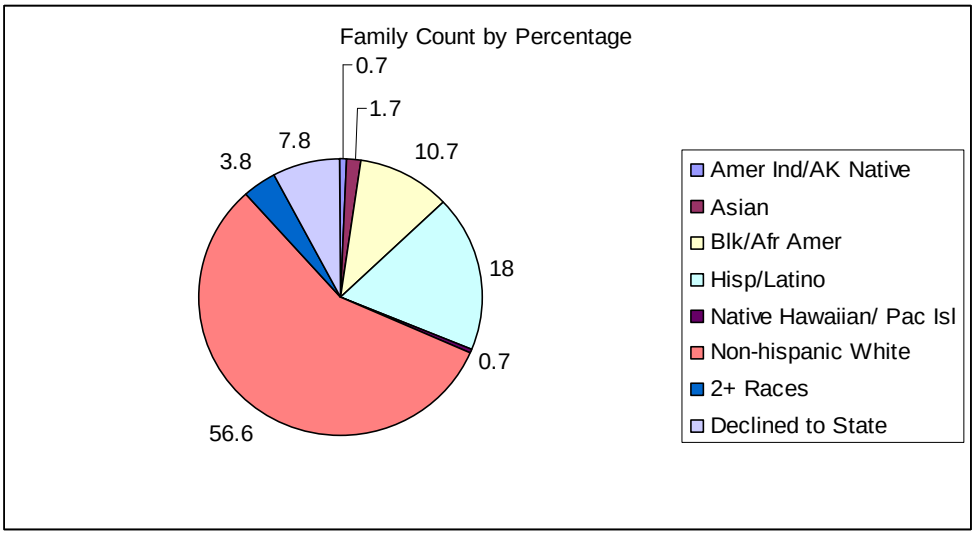
Racial/Ethnic Background:

The IDEA is a civil rights legislation that applies to all public education systems. To measure our compliance with equal access to services, we must collect racial/ethnic data on Families referred for EIS. DoD began requiring collection of racial/ethnic data during the SY 05/06 reporting period and established the categories used for this data. The data indicates that Army EDIS does not over or under identify minorities and provides equal services to all.

The data collection categories changed significantly after SY 05/06 and will not be used to measure performance over time. Therefore, this current report compares the past two reporting periods only.

This DoD established similar racial/ethnic categories as the U.S. Department of Education requires for public education programs. DoD added a category for two or more races and "Declined to State". This last category will not be used in future reports. Chart 6 below displays the racial/ethnic profile of Families enrolled for EIS in Army EDIS programs.

Chart 6
Racial/Ethnic Background of Families who Received EIS During SY 07/08



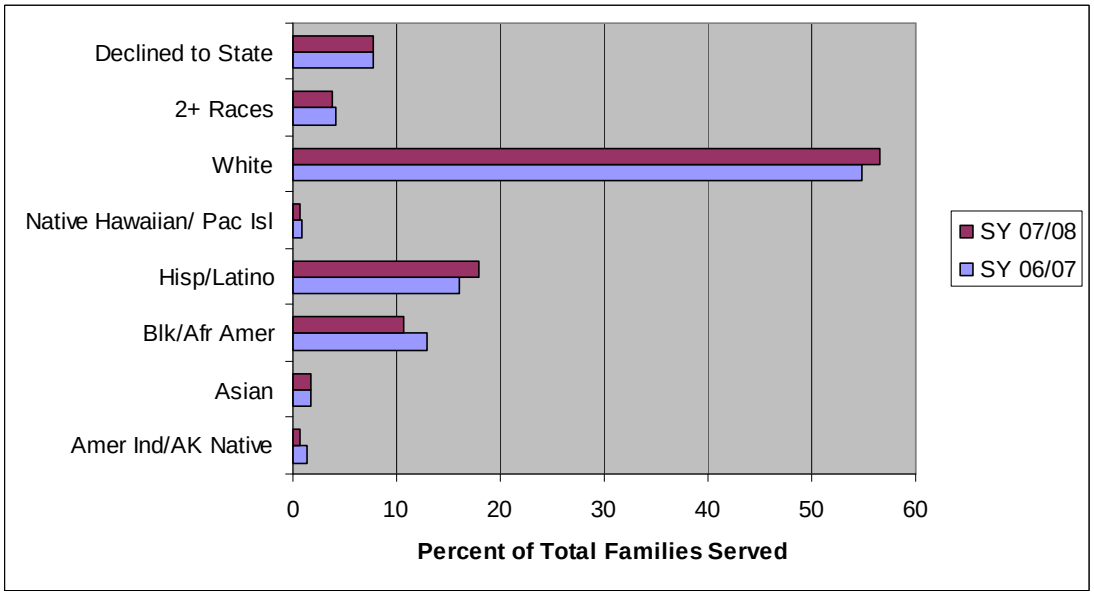
Three of the seven reporting categories contain over 85 percent of Families receiving early intervention services. The data shows that 56.6 percent of Families who received EIS report themselves as being non-Hispanic white, 18 percent are Hispanic or Latino, and 10.7 percent are black or African American. Nearly 4 percent report themselves as two or more races, and nearly 8 percent declined to state their racial or ethnic background. The remaining 3 percent

included American Indian or Alaska Native, Asian, and Native Hawaiian or other Pacific Islander.

When comparing this year's racial/ethnic data with last year's data, we find that the percentage of all minority categories decreased slightly, with the exception of Hispanic/Latino, which increased from 16 percent of the total EIS enrollment to 18 percent of the total Army EDIS enrollment. Although it appears to be a small increase, the actual count of Hispanic/Latino Families receiving EIS has grown by 5% from last year, while the count in all other categories has decreased.

Chart 7 illustrates the changes in racial/ethnic backgrounds reported by EIS enrolled Families during the past two reporting periods. Although the percentage of non-Hispanic white Families increase by nearly 2 percent of the total EIS enrollment, the actual count of these Families dropped by 3 percent. This apparent discrepancy is a result of the decrease in the total count of Families served (all racial/ethnic groups), while the non-Hispanic White group still remains proportionally the largest.

Chart 7
Racial/Ethnic Composition of Families Receiving Early Intervention Services
(by percentage of total enrolled)



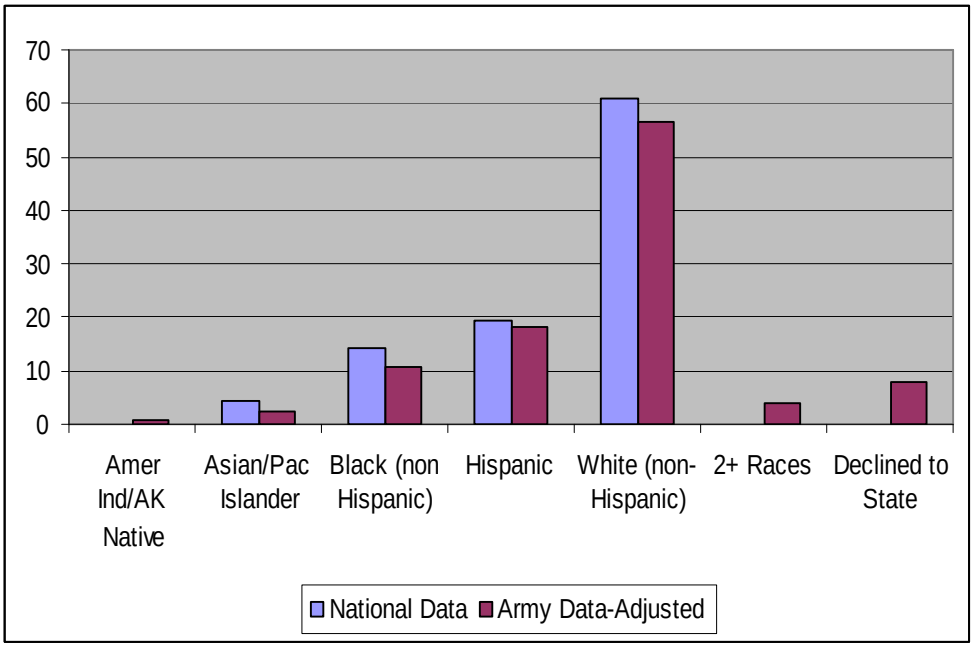
With only two years of comparison data, it is too early to assume that this change is a trend. However, this increase is consistent with National data from a variety of sources that report that the Hispanic/Latino population is the fastest growing minority group in the United States. The current EIS data would indicate a similar trend among military Families.

The total count within some of the racial/ethnic categories was too small to draw any conclusions from the data. However, the data within the three largest groups

(Black/African American, Hispanic/Latino, and non-Hispanic White) has greater reliability.

The current Army data appears very similar to the National EIS data from the 27th Report to Congress. The Army data in Chart 8 was adjusted for better comparison with the National data. The National data combined Asian and Pacific Islander into a single group, and did not include the two additional categories required by DoD.

Chart 8
Racial/Ethnic Identification of Children Receiving Early Intervention Services
National vs. Army



The number of Army Families who declined to state their racial/ethnic background, and those who identified themselves as two or more races, account for the slightly lower percentages in all other categories when compared with the National data. When DoD discontinues use of these categories next year, the comparisons with National data will be more accurate.

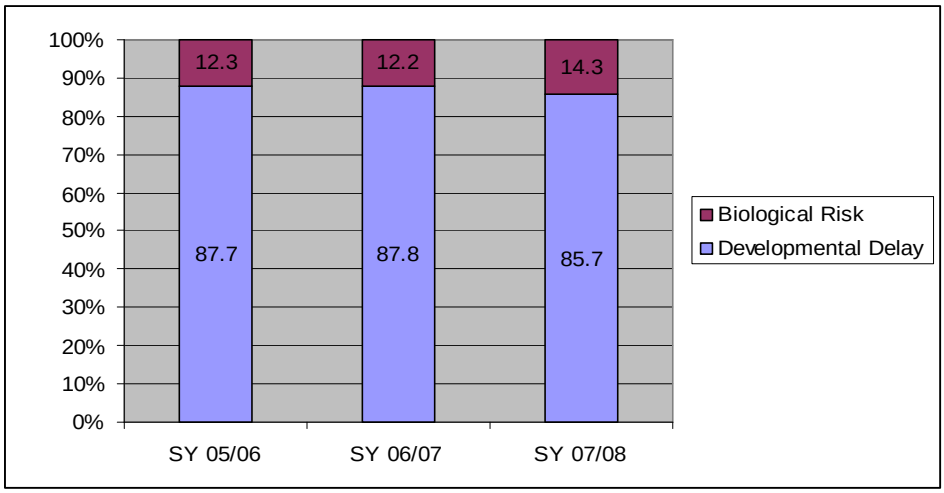
Basis for Eligibility:

In accordance with DoD policy, children may become eligible for EIS within two categories: a) Developmental delay, and b) biological risk. Multi-disciplinary teams assess development in five functional areas: Communication, social/emotional, cognitive, physical, and adaptive. Developmental delay is established if the children demonstrate a 2 standard deviation (SD) delay in one functional area or 1.5 SD in two or more areas.

Children may become eligible for EIS based on biological risk if they have received a diagnosis by a physician of a medical or psychological condition with a high probability of resulting in developmental delays.

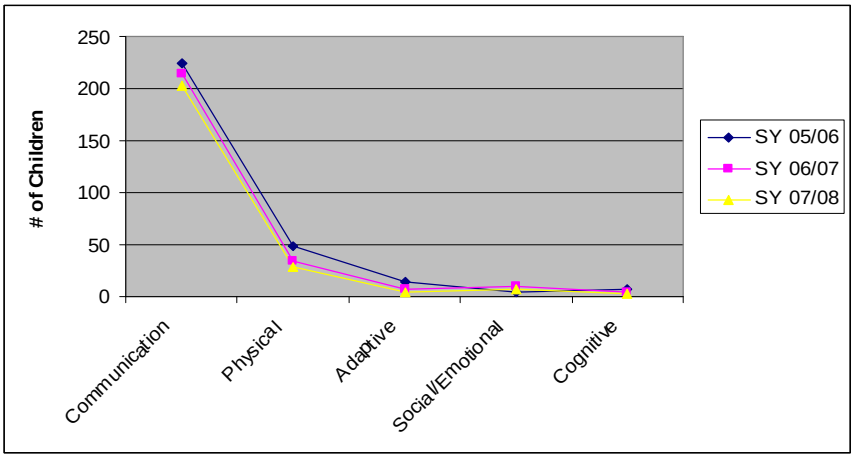
Of all children made eligible for Army EIS during this reporting period, 85.7 percent of eligibilities were based on developmental delay and 14.3 percent were based on biological risk. Chart 9 shows these proportions over the past three years, and the change over time is minimal.

Chart 9
Basis of Eligibility for Army EIS



Of all children eligible based on developmental delay, 44.2 percent had delays in only one functional area, and 55.8 had delays in 2 or more areas. Chart 10 shows the number of children in Army EIS whose eligibility was based on delay in a single functional area.

Chart 10
Children who Became Eligible for Army EIS Based on a Single Area of Delay



Communication delays are the most common concern that brings parents into early intervention services. Of all children who became eligible for Army EIS, 36.3% were eligible based solely on communication delays. Similarly, the National data shows that 34 percent of parents who bring their children to EIS cited delays in communication as a main concern, and the evaluations revealed a total of 39 percent actually had communication delay as an eligibility factor.

Service Plans and Service Delivery:

All services provided to children eligible for EIS must be based on a written service plan that defines the type of service, the frequency, intensity, and environment. The SNPMIS data system tracks compliance with this requirement. Table 2 shows the level of compliance with delivering all required services to children and Families. The data was adjusted for parent cancellations and holidays. Army EIS met 97.3 percent of all service sessions required during this past reporting period.

Table 2
Total Projected Services Met

Projected Services on Service Plans	15,796
Minus Sessions Cancelled by Parents	2,915
Minus Holidays	66
Net Projected Services Required	12,815
Minus Services Delivered	12,472 (97.3%)
Balance – Unmet Services	343 (2.7%)
Cancelled by EDIS	635 (5%)

Although EDIS cancelled 5 percent of the required sessions, half of those sessions were made up, resulting in only 2.7 percent of the net projected services unmet.

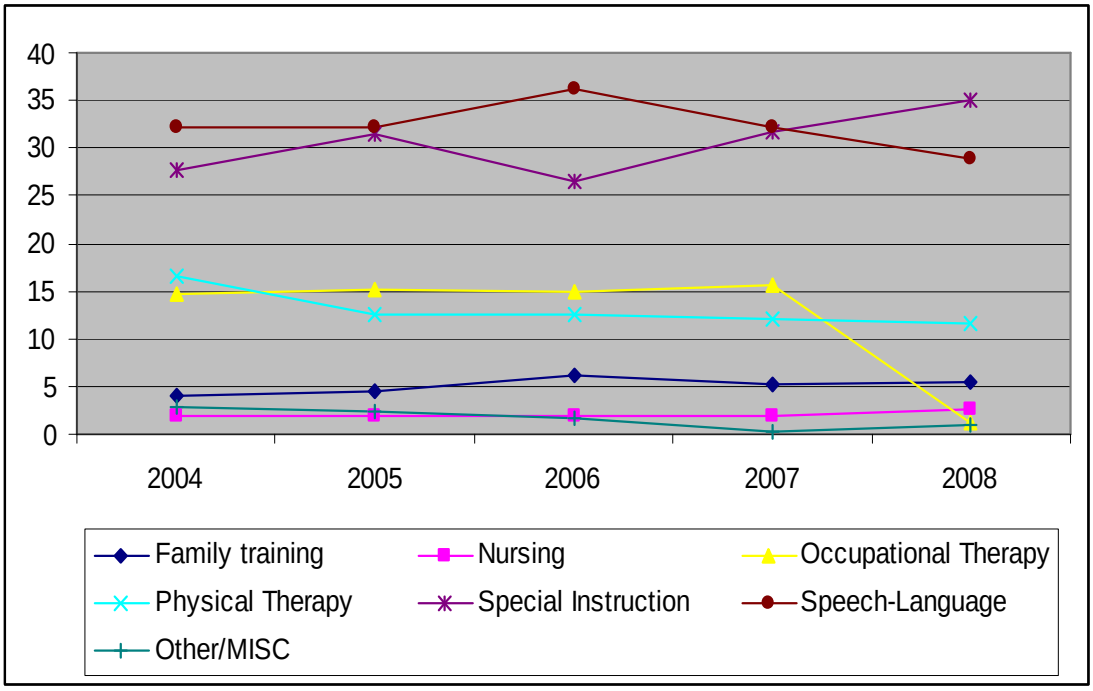
Best practices in the field of early intervention have changed over the years, from a system that treated deficits to one that emphasizes strengths and family-centered care. With this shift in thinking, EIS moved toward a relationship-based program utilizing a primary provider model of service delivery. This model is based on the premise that the parents are the primary teachers and caretakers of infants and toddlers, and can make the biggest difference in the child's functional independence.

The primary provider model gives support, information and training to Families to help them understand their children's needs, give them skills to encourage learning, and advocate for their rights. The Army EIS data reflects this paradigm

shift, through greater use of educators as the primary providers, with the support of multiple disciplines to evaluate, consult and monitor progress.

Chart 10 indicates the types of services on all IFSPs developed during the current reporting period. This data reflects the trans-disciplinary nature of EIS in the Army and the shift toward an educational philosophy. For the first time since the implementation of EIS, we see special instruction as the most frequently prescribed service. Because communication delays most often bring children into EIS, Speech Language Pathology will always be highly prescribed.

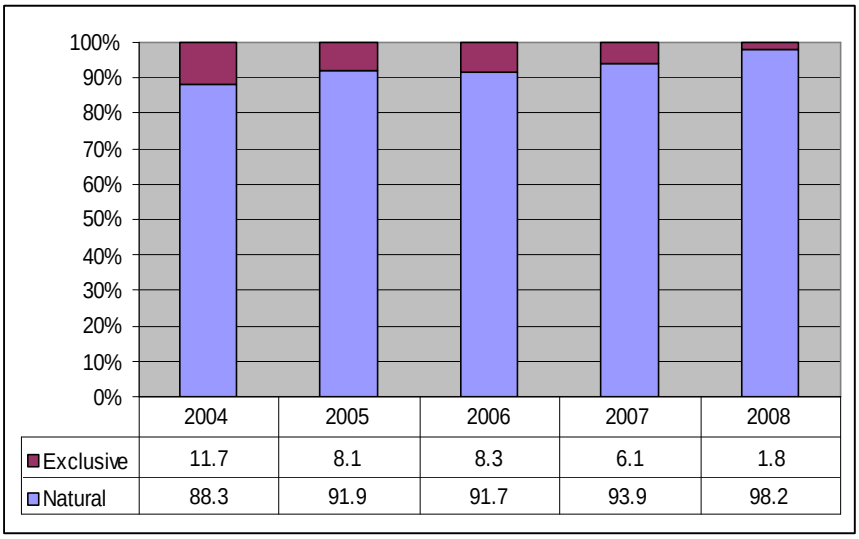
Chart 10
Types of Services Listed on IFSPs by Percentage of All Services



Natural Environments:

With each reauthorization of IDEA, Congress has placed greater emphasis on serving children with special needs in the least restrictive environment. For EIS it means the natural environment in which the child and Family spend most of their time and where they must function successfully. This legislative change goes hand in hand with the paradigm shift discussed in the previous paragraphs. The Army EIS has remained on the cutting edge of best practices in the field of early childhood intervention and has implemented a program of services embedded in Family routines that support the needs of Families in their own natural environment. Chart 11 shows the progress Army EDIS has made over the years with achieving a truly family-centered program of services.

Chart 11
Location of Services Listed on IFSPs by Percentage of All Services

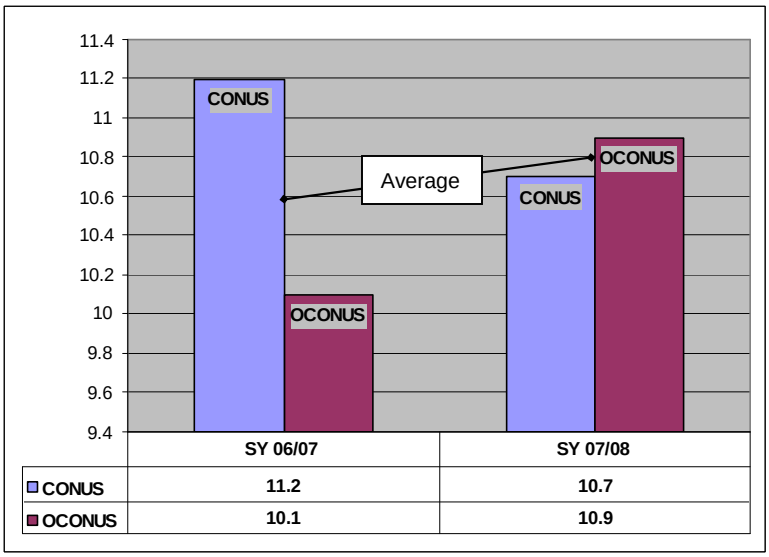


	2004	2005	2006	2007	2008
Exclusive	11.7	8.1	8.3	6.1	1.8
Natural	88.3	91.9	91.7	93.9	98.2

Length of Time in EIS:

Although this area is not a compliance item, collecting information on the length of time children spend in EIS can support management decisions. High turnover of children in and out of the program results in more frequent initial evaluations and transition activities. These are labor intensive activities. Chart 12 shows the changes in the length of time children spend in EDIS.

Chart 12
Length of Time in Early Intervention Services (in months)



	SY 06/07	SY 07/08
CONUS	11.2	10.7
OCONUS	10.1	10.9

The average length of time that infants and toddlers receive services from Army EDIS has not changed significantly over the past few years. Children spent an average of 10.8 months in the EDIS program during SY 07/08, up from 10.6 months during previous reporting period.

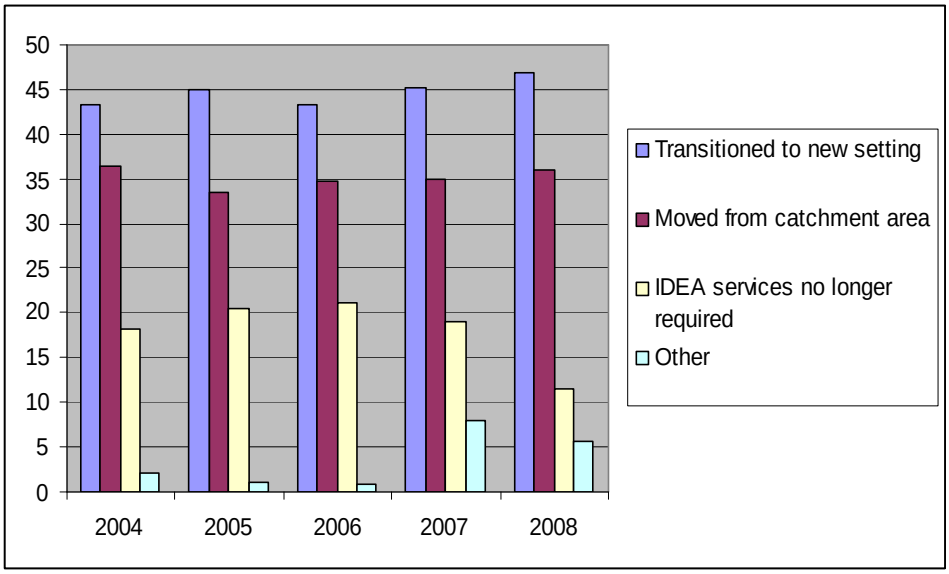
Approximately half of the Army EIS enrolled Families are stationed in Europe. With the ongoing restructuring and rebasing efforts, one would assume that the turnover of enrollment is greater overseas than at domestic programs. Surprisingly, during SY 07/08 the data shows completely the opposite. Families have been more stable in overseas programs (10.9 mos.) than at domestic locations (10.7 mos.). This is a significant change from the previous reporting period, when overseas programs served children an average of 10.1 months in overseas locations and 11.2 months in domestic locations (see Chart 12).

As the Army restructuring comes to full fruition, stabilization of tours will result in children remaining in these programs for longer periods of time.

Transition Out of EIS:

Legislation and DoD policy requires a seamless transition out of EIS to other follow-on services. This would typically be a special education program in a public school. With military Families, the concept of transition takes on alternate meaning. The Army collects data on twelve types of transitions that military Families may require. The data displayed in Chart 13 was aggregated into three major categories, with the remainder under "other". Nearly as many Families transition from EIS because they move from the catchment area as those who transition to the DoD school programs.

Chart 13
Types of Transitions out of EIS



Measuring Outcomes:

The latest reauthorization of IDEA strengthens the language that requires measurable outcomes in early intervention programs. This language also clarifies that the measurable outcomes must be functional and meaningful to children and Families.

In the past, compliance with legislation and accountability to the public was measured by the number of services delivered relative to the number required on the OFSP. Research in early childhood intervention conducted during the late 1990s revealed that repeat clinical services (OT, PT, SLP, etc.) provided little or no advantage over natural maturation in young children with developmental delays. Clinical services were more likely to focus on the child's deficits, rather than on building on strengths that would enable the child to function successfully.

In response to these studies, the Early Childhood Outcomes (ECO) Center developed recommended five functional outcomes statements for Families and three for children. These were then endorsed by a consortium of State level coordinators of early intervention programs. The Table 3 lists the child and Family outcomes adopted by a majority of the State early intervention programs and by Army EDIS.

Table 3
Child and Family Outcomes Measures

CHILD OUTCOMES:	1. Children have positive social relationships.
	2. Children acquire and use knowledge and skills.
	3. Children take action to meet their needs.
FAMILY OUTCOMES:	1. Families understand their children's strengths, abilities and special needs.
	2. Families know their rights and effectively communicate their children's needs.
	3. Families help their children develop and learn.
	4. Families feel they have adequate social support.
	5. Families are able to access services and activities that are available to all Families in their communities.

Army EDIS began training all program staff on the implementation of outcomes measures during this last reporting period. Modifications to the SNPMIS will allow the routine collection of outcome measures and the ability to aggregate these data across all Army EDIS. Early results will be available for the SY 08/09

reporting period, and formal reports of outcomes measures will be included in the SY 09/10 Annual Report of Compliance to DoD.

RELATED SERVICES (RS) TO SPECIAL EDUCATION STUDENTS (age 3-21)

Army EDIS provides RS as a support program for the DoD schools within the geographic areas assigned by DoD. Although DoDEA maintains the official data on RS as part of the special education program, EDIS collects data for program management and process improvement activities.

Population Served:

The school enrollment in Army areas of responsibility have dropped significantly over the past 8 years. While DoDDS enrollment dropped by 20.17 percent world-wide, the schools with large concentrations of Army children dropped by 23.63 percent. Table 4 shows the decline in school enrollment in the various geographic areas where Army has responsibility for EDIS.

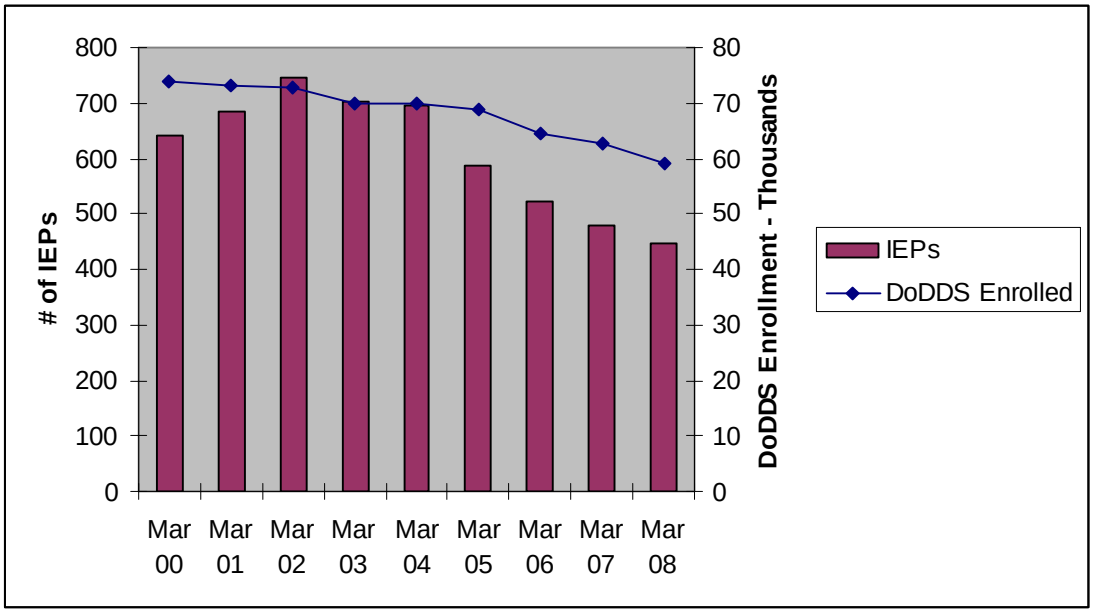
Table 4
DoDDS Enrollments in Army Areas of Responsibility

	Belg/Neth	Germany	Italy	Korea	Army Total
SY 99/00	2402	30884	1025	4005	38316
SY 00/01	2402	30238	988	3838	37466
SY 01/02	2271	30606	1065	3835	37777
SY 02/03	2320	29256	1075	3803	36454
SY 03/04	2181	28876	1106	4090	36253
SY 04/05	2152	28030	1120	4168	35470
SY 05/06	1413	26384	1344	3999	33140
SY 06/07*	2073	24615	954	3991	31633
SY 07/08**	2200	22296	929	3836	29261
Percent Change	-8.41%	-27.81%	-9.37%	-4.22%	-23.63%

* Two AFNORTH schools (604 students) shifted from the Germany district to Belg/Neth.
** Two Netherlands elementary schools (220 students) shifted from the Germany district to Belg/Neth.

Chart 15 shows the decrease in IEPs relative to the total DoDDS enrollment in the schools served by Army EDIS. Several factors could account for this difference. Although the DoDDS enrollment began dropping in SY 00/01, the EDIS programs did not see the effect until a year later. From March 2002 through March 2008, EDIS experienced a 40 percent drop in IEPs counted on 31 March of each year, while DoDDS enrollment declined by only 19 percent.

Chart 15
Decline in Total DoDDS Enrollment vs. IEPs in Army Areas of Responsibility



This disparity does not have a clear explanation, although certain initiatives within EDIS and DoDDS would certainly have impact on the number of services EDIS provides to students. Over the past several years, Army EDIS has worked diligently with DoDDS to ensure that IEPs developed for students contain only educationally appropriate services, and not primary health care services. In addition, a collaborative effort between DoDDS and EDIS to provide pre-referral consultation for behavioral concerns has resolved problems and resulted in fewer children receiving related services on their IEPs.

The pre-assignment screening through the Exceptional Family Member Program (EFMP) would preclude the assignment of Family members with chronic or acute medical conditions requiring sub-specialists. This would have a small impact on the number of IEPs requiring related services through EDIS.

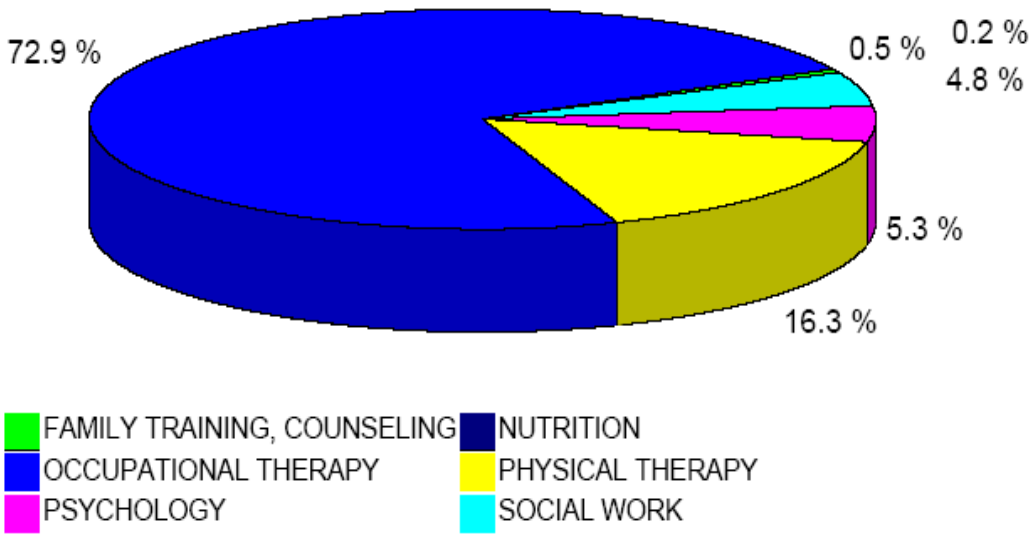
Services Provided:

Children who are suspected of having an educational disability are referred to a school-based committee. A school will send a request for an evaluation whenever there is need for EDIS to be involved in the evaluation to determine the need for special education, or the programming necessary to meet the needs of child. If the school-based committee (with EDIS participation) determines that a child needs a related service to benefit from special education, or if a child enters the school with an existing service plan that requires a related service, the school will send a request for services to EDIS.

During the current reporting period, EDIS overseas received 549 requests for evaluation of school-aged children, and 642 requests for services from the DoDDS. The total of 1,191 requests received by EDIS during the SY 07/08 reporting period is 5 percent fewer than the number reported during the previous reporting period.

Occupational therapy continues to be the primary service provided by EDIS to support the DoDDS special education program, making up nearly 73 percent of all school-based services (see Chart 16). Physical therapists provided just over 16 percent of all school-based services. These proportions have not changed over the past 5 years.

Chart 16
Related Services Provided on Individualized Educational Plans



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A. Monitoring

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1. Monitoring Approaches and Activities:

Army Monitoring Approaches: In July 2002, The MEDCOM issued a policy requiring a 3-tiered process for ensuring compliance with DoD standards. These methods include local program self-assessments, formal compliance monitoring by the Regional Medical Commands (RMCs), and compliance verification by HQ MEDCOM through random on-site visits, data calls, and reports. Each EDIS program must have a formal compliance monitoring every three years by a higher headquarters. Successful formal compliance reviews by a higher headquarters result in a *MEDCOM Certificate of Full Compliance.*

Army EDIS policy requires the Regional Medical Commands to conduct annual one-site visits to each program as part of the Command Organizational Inspection Program (OIP). These OIP visits review the program's status and provide technical assistance and training to address any concern that may lead to non-compliance. In addition, each Regional EDIS Manager has centralized access to the SNPMIS for their region and continually monitors the data for any signs of potential non-compliance.

Army Monitoring Activities: Army monitoring activities include a thorough examination of EIS, with limited review of RS in overseas locations. The DoDDS system provides accountability for RS compliance through the Reports of Unavailable Medically Related Services (RUMRS) as discussed later in this report.

Table 5 lists all the formal compliance monitoring activities within Army EDIS during this reporting period. Counting all monitoring activities conducted, ten (10) were by a Regional Medical Command staff, seven (7) by HQ MEDCOM, and 2 were DoD compliance visits. Out of 22 Army EDIS programs, 14 different programs were monitored, with six (6) programs receiving follow-up monitoring visits.

Follow-up visits by the RMCs were conducted to verify corrective actions from prior visits. The HQ MEDCOM follow-up visits were intended to verify that the RMC applied the standards correctly and consistently across all programs, and took the form of a full compliance monitoring activity.

Although Army monitoring activities found that three programs did not fully meet all the DoD compliance standards, there was no evidence of systemic non-compliance issues in domestic locations. Findings cited partial non-compliance in a single standard at two programs (immediately corrected).

One of the overseas EDIS sites monitored had major non-compliance concerns due to staff shortages that resulted in unmet service needs to special education students in the schools, and under-served infants and toddlers.

Table 5
Compliance Monitoring of ARMY EDIS Programs by Higher Headquarters – SY 07/08

Month	Regional Medical Commands (10 visits)	HQ MEDCOM (7 visits)	DoD/DoDDS (2 visits)
Jul 07			
Aug 07			
Sep 07	1) Vicenza, Italy 2) SHAPE, Belgium	1) SHAPE, Belgium (follow-up) 2) Weisbaden, Germany	
Oct 07			
Nov 07			
Dec 07			1) Yongsan, Korea **
Jan 08	3) Ft. Benning, GA * 4) Ft. Rucker, AL		
Feb 08		3) Yongsan, Korea (follow-up) **	
Mar 08	5) Ft. Stewart, GA *	4) Ft. Rucker, AL (follow-up) 5) Ft. Benning, AL (follow-up)*	2) Germany: Bavaria District - Ansbach, Grafenwoer, Stuttgardt ***
Apr 08	6) West Point, NY 7) Bamberg/Schweinfurt, Germany 8) Heidelberg, Germany		
May 08	9) Ft. Jackson, SC 10) Landstuhl, Germany (follow-up)		
Jun 08		6) Baumholder, Germany 7) Landstuhl, Germany (follow-up)	

* Minor administrative findings
** Major program compliance findings.
*** No report received to date.

2. Joint monitoring activities with DoDEA to review related services: The related services portion of EDIS is a subcomponent of the special education services provided by the DoDDS. Monitoring of related services is included in oversight and monitoring conducted by DoDDS, with involvement of EDIS managers. The Army EDIS staff provided assistance and information to the DoD monitoring team, but did not formally participate as members of a DoDDS monitoring team at the Army EDIS sites.

A DoD team monitored the delivery of IDEA services in the DoDEA District of Korea in Dec 07 and Bavaria, Germany in Mar 08. The DoD team found EDIS Korea to be out of compliance with the DoD monitoring standards and DoD Instruction 1342.12. Findings included unmet needs and under-served children in both RS and EIS due to lengthy vacancies or too aggressive downsizing of GS personnel in a theater undergoing military transformation and re-structuring.

3. Corrective actions related to DoD Monitoring: DoD monitored compliance of EDIS Korea in Dec 07. The HQ MEDCOM EDIS Program Manager conducted an OIP and monitoring of EDIS Korea in Feb 08, two months following the DoD monitoring activity. This OIP was in response to informal notification to HQ MEDCOM that the DoD visit found significant concerns with EDIS in Korea. However, MEDCOM did not receive the final DoD report of monitoring until July 08.

Although the USA MEDCOM has not had direct command authority or responsibility for medical services in Korea until Nov 07, on-site and remote technical assistance and resource support has been provided continually for more than a decade.

The MEDCOM OIP report cited similar findings and recommendations as the DoD report. Responsibilities for corrective actions were assigned to both HQ MEDCOM and EDIS Korea. Corrective actions include:

a. The MEDCOM OIP visit generated a plan to bring EDIS Korea into compliance with DoD standards. The plan includes:

(1) Increase staffing for both RS and EIS.

(2) Establishing satellite offices in Camp Humphreys/Osan area and at Camp Casey.

(3) Continuous training of providers on EDIS requirements, and required EDIS manager attendance regular attendance at the Annual Army EDIS Program Manager's Workshop.

b. Actions already accomplished to support these corrective actions:

(1) Headquarters, MEDCOM has programmed resources beginning in FY 09 to increase contracted EDIS personnel in Korea and to establish satellite offices At Camp Casey and at Camp Humphreys in support of the restructuring of the military in Korea.

(2) The MEDCOM has issued guidance that EDIS will be resourced to provide EIS to non-command sponsored children.

(3) The MEDCOM provided staff training in February 08 and again in June 08. Additional training is scheduled for September 08.

(4) The MEDCOM will conduct a follow-up visit during Sep 08 and again in Feb-March 09 to verify status of corrective actions

4. Request for redacted copies of due process hearings under IDEA: No due process hearings were conducted during the period.

5. Mediations: Army EDIS received no requests for mediation during the reporting period.

6. Number of requests for due process hearings, and number conducted: No requests for due process were filed by Families during this reporting period.

7. Reports of unavailable related services (RUMRS): DoDDS schools are required to submit reports when EDIS is unable to evaluate a student in a timely manner. Schools submit reports up both the DoDEA and EDIS chains' of command. Efforts are made to resolve RUMRS at the lowest level. This report contains RUMRS that were submitted to the DoD level.

Service	Location	Number Filed	Date Filed	Date Resolved
EDIS-KOREA	14 RUMRS were submitted to the local EDIS program and resolved locally. They were not forwarded to DoD.			
EDIS-EUROPE				
OT	Landstuhl	8	O9/27/07	10/19/07
Psychology	Landstuhl	3	09/27/07	10/03/07
Psychology	SHAPE	4	03/14/08 04/18/08 (2) 06/13/08	04/01/08 05/22/08 (2) 06/16/08

B. Program Initiatives

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Program Initiatives

Army EDIS continued or built on system-wide initiatives from the prior year. All initiatives were generated through collaboration between the HQ Army MEDCOM and the Regional EDIS staff, and fell into two distinct areas. Major initiatives include:

1. Service Delivery, Quality, and Compliance:

(1) Last year, the Army EDIS adopted the functional outcome measures for children and Families developed by the Early Childhood Outcomes Center and endorsed by the U.S. Department of Education, Office of Special Education Programs (OSEP). During this reporting period, the Army deployed the "child outcomes measures", developed and published staff training modules, and conducted training of all Army EDIS staff. Navy EDIS requested to use the same measurement system and received training from the Army. Family outcomes measures will follow during the next reporting period.

(2) To enhance the measurement of functional outcomes, Army EDIS implemented "routine-based" assessments and interventions in EIS and continued progress toward implementation of a "primary provider" model of early intervention services. These are considered as best-practices in the field of early intervention.

2. Policy, Training and Program Support:

(1) The Army revised the MEDCOM policy for EDIS and updated required forms we to provide to encourage implementation of best practices and to support.

(2) The revised Army EDIS policy provides detailed guidance on a Comprehensive System of Personnel Development (CSPD). The CSPD will require competency-based staff training modules that will lead to certification of competence for EDIS staff.

(3) Continued publication of monthly "Keeping in Touch" articles, aimed at improving quality of services and management of programs. Keeping in Touch is part of the overall system of personnel development and shared with Air Force and Navy EDIS programs.

(4) Army EDIS continued resource sharing among installations and regions to address the increasing shortage of qualified early intervention professionals in the United Stated, and to maximize available professional staff within the Army and DoD.

(5) Continued extensive analysis of longitudinal data from the Special Needs Management Information System (SNPMIS) to re-assess overall program and resource requirements.

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C. Operational Data Tables

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